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**'Trying to Cope' – An Ethnographic Account of Depression, Isolation and  
Ways of Coping, in a Youth Homeless Centre**

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## **‘Trying to Cope’- An Ethnographic Account of Depression, Isolation and Ways of Coping, in a Youth Homeless Centre**

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**Key Words:** Ethnography, Homelessness, Depression, Youth

### **Abstract**

The paper explores depression, isolation and ways of coping, at a youth homelessness centre. The aim being to capture some early experiences, with a view to how these could begin to be understood before becoming entrenched.

Ethnographic research methods were used. The researcher spent two months conducting participant observation at a drop-in centre and hostel.

The research supports conclusions of larger studies, that young homeless individuals are particularly vulnerable to poor mental health and risk taking behaviour, and that more research is required about mental health promotion approaches used in this sector.

### **Introduction**

The intention of this paper is to describe primary ethnographic research, exploring the feelings of depression and isolation, and coping behaviours of young homeless people.

The report ‘Bright Futures: Improving the Mental Health Needs of Children and Young People’ (Mental Health Foundation 2002) describes ‘Young homeless people as being one of four key groups identified as being at risk of developing mental health difficulties. Homeless young people are highly vulnerable due to their age, and the experience of homelessness can exacerbate existing mental health problems or contribute to the onset of these.’

This study was carried out in a generic homelessness setting, rather than a specialist mental health service. The aim being to capture some early experiences of common mental health problems and coping behaviours, with a view to how these could begin to be understood and addressed before severe and enduring problems occur.

### **Literature Review**

The report ‘Making the link between Mental Health and Youth Homelessness’ (Mental Health Foundation and Centrepoin 2006), highlights that over two thirds (69%) of the young homeless people aged 16-25 surveyed, reported having mental health problems. Half (50%) experienced regular feelings of anxiety and depression. Craig et al (1996) describe a longitudinal study which found that 70% of young homeless

people had been diagnosed with depression, or had concerns about their mental health.

Chatrick, cited in Coombes (2004) reiterates the importance of addressing young homeless people's common mental health needs promptly, before they become entrenched. The timescale surrounding this 'entrenchment' is difficult to pinpoint, as the balance between the role of personal histories and the role of structural changes continues to be a source of debate, along with which came first – mental health problems or vulnerability to homelessness (Mental Health Foundation 2002).

Indeed 80% of homeless young people using Centrepoin's services, have left home due to 'push factors' (Shelter 2005). These are the negative factors, usually occurring when young people are forced to leave the family home in an unplanned way. These young people are likely to have experienced family conflict, which may have already become an entrenched way of living for them.

A review of both anthropological and health focused literature showed a limited amount of ethnographic research about youth homelessness and mental health difficulties. Most anthropological literature either focuses on chronic mental illness amongst homeless adults, or the lives of street children in non-western settings.

Veitch and Wigmore (2003) argue that qualitative research allows some insight into the world of homelessness that may not be available to quantitative methods. The whole notion of homelessness is subjective and fluid, so conducting research in this area is not as simple as numbering those who have no access to appropriate housing.

The research presented here will focus on the experiences of young people who may have become homeless recently, and who are at an age that makes them vulnerable to mental health problems.

## **Methodology**

The research presented, was completed as part of an MSc in Medical Anthropology. Ethnography is the main research method of social anthropology, and is used in this study.

Generally, ethnography refers to the description of people and their culture, in this sense the subject matter, human beings engaged in meaningful behaviour, guide the mode of enquiry and orientation of the investigator (Altheide 1987).

In ethnographic research, all meetings, interactions, social exchanges, and the environment are placed into meaningful context. Part of this context, involves openly acknowledging the presence of the researcher. So, the 'first person' will be used in this paper where appropriate, this is indicative of ethnography conveying a sense that the researcher is embedded in the process.

The field work took place, in a drop-in centre and hostel for homeless young adults, in a large British city. There were 24 beds in the hostel, and approximately 20 individuals used the drop-in centre on a daily basis. I

worked as a volunteer in both sites, giving me the opportunity to conduct participant observation with the client group of 16-25 year olds. For the purposes of this paper, I have selected a sample size of six from the original field notes, with four clients and two situations being described.

The field site was in the centre of the city, where there were a considerable number of young adults both 'rough sleeping' and residing in hostel accommodation. Due to this location it was deemed this field site was a fairly typical youth homelessness project, and so despite the limited scope of place, time and numbers of participants, it is felt the findings could be transferable.

Ethical approval was granted by the appropriate University. The research topic was also discussed with the 'gatekeepers' of the centre, the managers of services. They were interested in my ideas, and certainly felt that a number of their clients were experiencing isolation and depression, and this warranted further study.

Due to all clients being made aware of the reasons for me working there, informed consent was sought verbally from each individual specifically included in the study.

I needed to be aware of issues of confidentiality and the voluntary nature of participation in the research. Both the centre's and city's name have been removed, and I have replaced all client and staff names with pseudonyms.

Barton (2008) describes how participant observation is a primary technique used by ethnographers to collect data. The aim of the ethnographer, being to purposely interact in the sample's world. I used participant observation, throughout the eight weeks of my field work. The purpose being to discover a perspective, in so far as possible, that sees the world through the eyes of the study group. Thus the majority of the data was collected through observation and interpretation of daily events as they naturally occurred.

I worked as a volunteer for three long days (approximately 9-10 hours) per week, in the hostel and drop-in centre, it enabled me to gain a comprehensive view of the centre. My duties included; 'manning' the drop-in centre desk and welcoming new clients; making sandwiches and snacks with clients; helping individuals find emergency and longer term accommodation; assisting with group activities; completing client conferences when the key worker was away and 'manning' the hostel office. I also conducted some 'in-house' mental health training for staff.

I began assisting with individual client conferences after two weeks. I did not use a tape recorder, as I did not feel this was appropriate due to the guarded presentation of most of the clients. Almost certainly, it would have disrupted the discussion or intimidate them. Thus I took notes of all interactions, being very detailed and careful during what I perceived to be important conversations. I had plenty of time to transcribe notes during breaks, on my way home and in the evenings, although by not using a tape recorder I may have missed certain nuances and phrases.

I was also given access to the files staff kept in the office, and was able to gain background and bibliographical details here. The environment itself, including posters, paperwork and the surroundings, also provided rich data.

As the staff knew I was a Mental Health Nurse, they would ask me quite regularly 'Do you think there is anything wrong?' This sometimes put me in a difficult position as I was unsure of my role (volunteer, researcher but Mental Health Nurse). This required me to try and be reflexive throughout the process, acknowledging the possible conflicts between my perceived various roles.

My volunteer work at the hostel enabled me to collect relevant data from the general situations and events. To gain more detailed data, I was able to 'specifically target certain individuals to gain insights into their lives' (Barton 2008).

As I began to create relationships with the clients and staff, I gained some insight into individuals who were most comfortable talking about their experiences, anthropologists would name these 'key informants'. I was then able to spend more time with these individuals on an ad hoc basis, and during client conferences, to discuss various themes in more detail using open-ended unstructured questions. During this time we had the opportunity to explore some of their experiences, observations, thoughts and feelings. The aim of these conferences was to review progress and establish actions that needed to be undertaken in order to achieve future goals, namely regarding career/educational aspirations, health needs and long term stable housing. I asked some prompting and clarifying questions, but generally listened to what the young people had to say, as themes pertinent to the research topic naturally occurred. This I believe is a measure of the reliability of the study, as information is volunteered by the client, rather than elicited.

## **Analysis**

A thematic analysis was used to analyse the data. 'Thematic analysis focuses on identifiable themes and patterns of living and behaviour' (Aronson 1994).

All field notes were placed under general patterns. From these patterns emerge 'the informant's stories, that are pieced together to form a comprehensive picture of their collective experience' (Aronson 1994).

As highlighted in the literature review; common mental health problems such as depression, feelings of isolation and negative coping mechanisms, were prominent issues for young homeless people. In the data collected for this study, these topics also emerged as clear themes.

## **Findings**

A sample of four individuals and two situations has been used to explore the feelings of depression and isolation, and the coping skills of young homeless people.

The first two individuals presented here were 'street homeless', using the drop in centre.

Then the experiences of two hostel tenants are discussed. Two situations are then considered, to illustrate how common mental health and behavioural issues are embedded within youth homelessness culture.

Boulton (1993) points out that for young homeless people, the transition from living at home to being on the streets can be an abrupt one. This may leave the young person feeling very isolated, and ill prepared for the demands which living on the streets or in hostels makes on them.

‘David was 18 when he entered the drop-in, he was very quiet. He came in at 3.00pm and explained he had been rough sleeping in the local park for the past two nights. David was smartly dressed, and well kempt with clean white trainers, jeans and t-shirt. I had to explain that we would be unable to find him an emergency bed for that night, as these beds get taken quickly in the morning. He needed to come back at 9.30am in the morning, when every effort would be made to find him an emergency bed. David began to cry and said he was very frightened, and he got cold in the rain, he kept gesturing with one finger saying ‘please just one bed, I’m not fussy’. All we could do was offer him shelter line’s number, and encourage him to get some coffee and take some sandwiches. He was crying as he left, but did agree to return the next day. I was upset that we couldn’t help, Paul the project worker said ‘it was sad but there were loads of similar cases all over the city’. (Field notes June,2006).

‘David returned as advised the next morning. He was a little brighter, certainly less unsure as he entered the drop-in, saying hello and he had remembered my name’. (Field notes June,2006).

Paul, the project worker, located a nine night emergency bed at a nearby hostel. David was cheered by the news. He said he ‘just needed a bed that he felt safe in’. David reported to me that he had been approached regularly over the last few days for money, and that when rough sleeping, people were drinking lots of cider, and smoking cannabis. David didn’t smoke or drink, he informed me, but could understand why people did this especially when they were frightened and feeling so isolated, he also said people told him ‘if you said you has a drugs or drink problem, you might get a hostel quicker, as you would be called a priority’.

These points are particularly important. David didn’t want to turn to chemical comforters at this time of great vulnerability but it would certainly be understandable if he did. From a health point of view, it would be worrying if he did this, but from his point of view it could be seen as legitimate. Cider is a cheap form of gaining calories, it would help him sleep and it may make it easier for him to socialise or at least gain acquaintances. When clients picked up the directory of hostels and read over and over again ‘this is for people with substance misuse or alcohol problems’, it can be understood that this route could be regarded as a form of adjustment and adaptation to the realities of street life. David didn’t choose this route though.

‘David came in twice at 9.30am to look at longer term housing options with the project workers. He brought along his washing and had a shower both days, saying there was always a queue at the hostel. He helped himself to biscuits and coffee, and sat down to look through

the hostel directory himself. Though David remained quiet, he continued to acknowledge staff and other clients by saying hello, and I observed him sharing a newspaper with another client.' (Field notes 23, June, 2006).

In short, David demonstrated quite positive coping mechanisms. Even though his homelessness situation, and the reasons behind it could not be resolved over night, David was co-operating with staff; learning how to do his washing; gaining nutrition and very gently socialising with others. Over the course of the two weeks, he had stopped crying and was able to smile when saying hello, it appeared 'things' had been so frightening when he was having to sleep rough, that he was accepting and grateful for help in order for that not to occur again.

'Jo also came into the drop-in centre one afternoon seeking emergency accommodation. Jo was a man but lived her life as a lesbian woman. She was dressed in a unisex fashion, which could be interpreted as either gender, with black gothic clothes and dyed hair. But, certainly the cultural image she was portraying to those who did not know her was of a young man. She had some ID for a Miss Jones and insisted he was actually female, so was referred as a female to emergency accommodation in a dormitory,' (Field notes June, 2006).

The next day

'Jo returned to the drop-in, but we also received a phone call from the hostel saying they were annoyed. They felt Jo was a man and had been wrongly referred, and so they couldn't put her in a female dormitory as the other women would not accept this. Luckily, they had a spare room that night but the situation could not continue. Jo said at first she had no other ID, however after some time did produce a male birth certificate'. (Field notes June, 2006).

Jo had to face the very real adjustment that as she had now become homeless, and to come out of that situation, would need some form of communal living, she would have to rapidly address her gender issues. This was particularly difficult as she had suffered from depression (and other unspecified mental health problems diagnosed in the USA), linked to these issues. The acute situation of homelessness, forced gender questions to be asked, and forced answers. Jo's clothing, and hairstyle did not portray the image of a 'woman', and she was rapidly exposed to this by the reaction of fellow drop-in clients and hostel residents. In the world of emergency accommodation, where beds were for nine night stays, there was no room for negotiation or ease of adjustment to being homeless and the personal trials this would throw up in a variety of forms. It appeared that perception of one's self, one's situation and the messages one sends others would be key factors influencing the success of this coping process.

The support offered at the hostel, included a key worker system, where each resident was allocated a project worker, and client conferences were held at move in, after three months and so on. The aims of the client conferences, typed on the paperwork and relayed to the client were 'to help the process of adjustment, and develop goals and plans for the next period of residence'. Questions to be asked were 'how are you? What are your main support issues at present?' Further topics to be discussed included



independent living, health, education, training and employment, and maintaining abstinence.

As one key worker was away, I was asked to complete a client conference, a review of client's current needs and future plans. This conference was with Abigail, a 21 year old who had lived at the hostel for three months. Her situation can be summarized as follows: Abigail's mother threw her out of the family home after she began a relationship with her mother's partner's son. Though there was no biological connection, and neither had grown up together (the parent's relationship had only begun recently), Abigail's mother called the relationship incestuous and threw her out. Abigail had been diagnosed with depression, but informed me that both she and her doctor had decided that she should see how her move to the hostel made her feel, before trying any medication. Thus allowing Abigail time and space to see if support and a change of environment may help, or if a small dose of antidepressants may help her.

Abigail described how she found it difficult to talk about how she was feeling, as it was hard to explain. To quote:

‘ “Last year I was normal, I was doing a hairdressing course and working behind the bar. Then he came along and I met Jake and here I am, in a hostel for homeless people.” Abigail laughed and giggled nervously. “Can you believe it, I used to have a proper home and stuff”. I asked Abigail if she was still in contact with her mother, she shook her head and said “no”, saying “ that’s the way it is now, she wants to be with him, I can’t go back.”’ (Field notes June,2006).

The Homelessness Training Unit (2006) identifies sudden homelessness, lack of attachment in a community, lack of influence, and communication difficulties as all contributing to making young people vulnerable to stress and depression. Mechanisms that can protect against these vulnerabilities are social factors such as housing and income, external support systems that encourage and reinforce coping mechanisms and individual's attributes such as belief in self autonomy and self esteem.

The aims of these ‘client conferences’ were to try and assist in providing these types of protective mechanisms.

‘I was struck by how many nice things Abigail said about her key worker. She repeatedly said “she’s great, I can talk to her and she’ll listen. She helps me phone social security and college, and she doesn’t judge me.” I asked Abigail if she wanted to stay in the hostel for the full one year stay, and she adamantly said “no, no I’m 21, no it’s ok but it’s a bit like being at school. I’ve got skills, that’s what they call them, I can cook and clean, and have worked. No I’m looking into the Prince’s Trust, so I can start my own hairdressing business. Either rent a place in a salon, or do it mobile. I’ve gotta do this, so I can get a place of my own, the sooner the better!”’ (Field notes June,2006).

Abigail had said “Can you believe it?”, indicating many aspects of her world had changed very suddenly, notably her relationship with her mother and family, loss of peers, change of environment, change in status and even future plans and aspirations. Having to cope with all these difficulties at once, to have to adjust quickly to numerous changes, it is not surprising

she became depressed. Abigail felt the overwhelming distress this caused her after moving to the hostel, and so went to the GP. Prior to this she had been in a sort of survival mode, not unlike when she first went to the drop-in for help, and needed immediate assistance in claiming benefits and getting accommodation. When these emergencies had been dealt with, and Abigail made her move to the hostel, the huge change in circumstances hit her, and she had to start thinking about types of long term adjustment.

Another hostel resident, Kirsty had some deeply embedded difficult behaviours.

This information was taken from paperwork in the hostel office. Kirsty was 18, she was originally from Scotland but had moved to England about six months earlier. She had grown up in poverty, and was placed in various foster homes as her mother felt she could not cope with her behaviour. Kirsty's behavioural problems continued whilst in 'care', hence she was moved from foster family to foster family. Kirsty's mother and father were not married and her father had been in prison during her early years. Kirsty's mother married another man who was very violent, and both her mother and this man had a drink problem. Staff had told me Kirsty had become withdrawn and quiet over the last few months. When I spoke to her, she openly said "I'm so stressed, I'm so stressed!" She went on to say,

' "There's so much going on, I can't cope, I don't think I can. He's after me, he came down to find me, but when he couldn't he's gone back to Scotland and broke my mom's arm. I'm gonna have to move, coz he knows where I am, I'm not safe. Ahhhh....." Kirsty began crying and calling her step father a bastard' (Field notes June,2006).

Helman (2001) highlights the effect on mental health of social changes, and reminds us that we are culturally provided with ways of becoming ill, of shaping our suffering into a recognisable illness entity, and of explaining its cause and getting treatment. He highlights cultural influences on the language of distress, in which personal distress is communicated to other people. At times Kirsty demonstrated real difficulty in articulating her concerns eloquently or acceptably, and got into real rages in the office.

' " Fuck you, fuck you all, fuck off". She stormed out, slamming doors and leaving the building. On return Kirsty did not apologise but did acknowledge she had been stressed and down'. (Field notes June,2006).

Although Kirsty has done well in one sense, (she approached services for help and had been engaging with staff), her life could be regarded as chronically stressful. Kirsty had had difficulty coping and adapting to change throughout her youth, and sadly, just as she was making some progress her stepfather threatened her newly found tenuous stability, and she became very distressed. This distress led to a rise in inappropriate outbursts. These outbursts not only induced potentially stressful situations for herself, staff and other residents, but also made Kirsty unable to cope with an already difficult and isolating life.

Whilst conducting my participant observation, the centre staff underwent a two day mental health training course. This was in response to an interest in the mental welfare of young homeless people, and also to concerns

about how to deal with the behavioural difficulties displayed in a proportion of clients.

An example of the kind of behaviour staff found challenging can be seen in the following incident.

'In the resident's meeting, eight clients arrived. They began eating all the crisps that had been provided and throwing these at each other. They constantly kept pushing each other and swearing saying "fuck off, no fucking way", "how long have I got to stay here, is this classed that we've attended so we can get ticked off?" (Part of the license agreement was that clients attended the meetings fairly regularly). When the project worker asked about any suggestions to improve the hostel, they started smirking saying "Make ganja legal, and that we can have loads of visitors for parties. We want no curfew so we can go clubbing". When the project worker tried to explain the rationale behind these rules, they kept interrupting' (Field notes April, 2006).

Outbursts of this kind were frequent, and usually occurred in situations where the young people felt constrained by rules. Although one of the purposes of the meeting was to ask for their input, their annoyance at 'having' to be there, over rode the opportunity to have their voice heard.

The staff themselves tried to address this, by setting up more informal groups focused on practical skills.

A men's group was already in progress when I volunteered at the centre, and a women's group was being planned. I was involved in some discussions surrounding the setting up of this group and the focus of these sessions. This was discussed amongst the female project workers and a small questionnaire was given to female clients. Certainly one focus that came out was the need to focus on inner personal strengths and mental health promotion, the clients had experienced such difficult problems that it was recognised it could be easy to say 'nothing is my fault or responsibility'. Thus the sessions were planned for ten weeks in advance with the group aims being to increase social networks, to work on finding alternatives to 'street culture', and to look at physical safety (with referrals to self defence classes). On a more individual level; the goals of the classes included promoting self esteem and sense of achievement through relationships; looking at creative positive role models through the form of volunteer mentors; building life skills such as cookery; and identifying ways to act in risky situations. Though these goals were idealistic, they were in response to what front line staff and clients had discussed. What the clients themselves had highlighted would help young people move forward and cope with current and future stressful situations. Though the classes were at a planning stage, I have since found out after finishing my fieldwork, they went very well with high attendance. This is interesting, as it had been difficult to motivate clients to attend college and other courses/groups, so the fact these early classes were popular is probably in response to clients finding them useful and non threatening.

## **Discussion**

It is certainly evident in my research findings that young homeless adults experience numerous stressors, which many of them are particularly ill equipped to deal with due to the very circumstances that lead to the homelessness in the first place. Thus the most vulnerable people find themselves repeatedly in the most difficult and challenging situations, with few, if any, skills enabling them to heal.

Despite this being a very small study, the data supports the conclusions of larger studies cited in the literature review. As the Mental Health Foundation (2002) acknowledges, there is a compelling body of evidence showing homeless young people are particularly vulnerable to poor mental health, risk taking behaviour and circumstances, and social exclusion.

Two key informants (Abigail and Jo) had medical diagnoses of depression. The roots of the depression appeared very different, but there still remained the challenge of dealing with this in an already stressful situation.

By the very nature of the field site, all the key informants were isolated to some extent. David and Kirsty's isolation was particularly poignant, as both were geographically a long way from home. David appeared to be becoming less isolated and more communicative towards staff and peers. Kirsty's isolation, however, was more deeply embedded because of her troubled childhood. So although surrounded by people at the hostel, she found it difficult to communicate appropriately, thus exacerbating her isolation.

Difficulties with communicating appropriately had a large impact on coping behaviours. This could lead to conflict with staff and other residents. However when given more control over their participation in centre activities, the young people became more interested and involved. This would suggest that it should be standard practice that young clients have a greater input into both content and planning of meetings/courses.

The centre acknowledged the impact of the stresses these young people had to endure, and the difficulties they had in overcoming them. Part of the centre's work involved the development of mental health promotion approaches, but any strategies are fraught with difficulties because of extremely complex causality of problems, and the difficult behaviours presented. Helping these young people is a significant challenge. This may indicate that staff require appropriate training, focused on mental health promotion and early mental health issues, rather than on severe and enduring mental health problems.

Seymour and Gale (2005) acknowledge that one of the most striking omissions from existing evidence is any review of interventions that examine the mental health/adjustment elements of programmes that aim to reduce inequalities. Research within these areas necessitates study of a community, making this suitable for future anthropological and ethnographic study, particularly for Mental Health professionals.

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